LINKAGES CASE MANAGEMENT PROGRAM

APPLICATION AND INFORMED CONSENT

I, (Applicant's Name**)**_____

Address:_____

Telephone No.: ( ) _____ Medi-Cal No.:_____

Social Security No.: _____

HEREBY APPLY TO PARTICIPATE IN THE LINKAGES CASE MANAGEMENT PROGRAM, SUBJECT TO DETERMINATION OF ELIGIBILITY.

I. PHILOSOPHY and SERVICES

The goal of the Linkages program is to prevent inappropriate institutionalization of frail, at risk elderly and functionally impaired adults by providing case management services and comprehensive information and assistance. Case managers work with clients and their support system to assess individual needs and locate, coordinate and monitor services that will enhance the client's ability to live in the community with optimal health, well being and safety.

I understand that Linkages case management services will consist of:

- An assessment of my health and social needs. The purpose of the assessment will be to determine if I am eligible to participate in the program and to provide the Linkages Case Manager with enough information about my needs to develop a plan of services to help me remain in the community; and,
- A care plan, developed by Linkages staff, with my participation if I choose to participate. With my approval, this care plan, will address my health, social services, safety or environmental needs to help me remain in the community; and,
- A Case Manager who will be assigned to me to be my primary contact for implementing the case plan and in the delivery of agreed upon services.

Initial:_____

II. CLIENT RIGHTS

I understand that I have the right to:

- Not participate in the Linkages assessment. However, if I choose not to participate, I will not be eligible for case management services from the Linkages program. This choice would not have any effect on current or future services and benefits I may receive, and information and referral services can be provided to me without an assessment.

II. CLIENT RIGHTS, cont.

I understand that I have the right to:

- A confidential relationship with the Linkages program. Information about me will be disclosed only to Linkages Program staff, service providers who will be serving me, specific persons to whom I have released information, or as required by funding/monitoring agencies or applicable state law. I will not be individually identified in any public reports about this program.
- Be involved in deciding what services I require and in any changes in the plan for services.
- Initiate a grievance of provision of services through the Linkages program.
- Discontinue services with the Linkages Program at any time.

Initial:_____

III. FEES AND LENGTH OF SERVICE

I understand that:

- Linkages utilizes a sliding fee scale and will apply the fee scale to the services I receive based upon my reported income
- Linkages case management services are available to clients for as long as the case manager, in consultation with their supervisor, determines there is a need for case management and I continue to desire services.
- Services may be terminated if and when an effective continuum of services is established, services are no longer needed or appropriate or my condition improves and consequently I am no longer eligible for service.

Initial:_____

_____ _____

Signature (applicant or responsible other) (Date)

I have explained the purpose of case management and the nature of the involvement of the client and/or responsible other person(s) acting on behalf of this client. I have answered all questions about case management and the assessment asked by the client and/or responsible other(s). I have provided a copy of the program grievance procedure.

_____ _____

Linkages Staff's Signature (Date)

Date copy provided to client:_____